Redacted

Redacted

CLINICAL FORMULATION *(Include interpersonal relationships, strengths, weakness patterns of coping, substance abuse, impressions as to vality of symptoms/information, diagnosis).*

Pt is

[redacted] and [redacted] who is charged for the [redacted] Pt. referred by medical staff due to c/o of feeling depressed, & self esteem, & sleeping problems after he got into a [redacted] accident and is currently confined to wheel chair due to his current neurological condition. —

Redacted

XIII. INITIAL DISCHARGE PLAN

XIV. REFERRAL FOR PSCYHOLOGICAL ASSESSMENT

In the space below, please state a referral question(s). Include the observations you have made that led to your request for testing.

N/A. —

C. Gerstat-Sayers MC 5/30/06 — Unit Chief PhD 5/31/06

Reviewed and Approved by Clinician—Printed Name and Signature — Date — Reviewed and Approved by Licensed Clinical Supervisor or Licensed Unit Chief—Signature — Date

acting M.H. Unit Chief

NEW YORK CITY HEALTH AND HOSPITALS CORPORATION
OFFICE OF CORRECTIONAL HEALTH SERVICES/MENTAL HEALTH SERVICES

CLINICAL ASSESSMENT AND COMPREHENSIVE TREATMENT PLAN/DISCHARGE SERVICE NEEDS

PATIENT: Reyes, Jason		BOOK & CASE #: 34906026 28	NYSID #: 04704424
(CIRCLE) MO / (GP) FACILITY: MC	HOUSING LOCATION: Inf. D3	DOB: 1-3-83	DATE OF ADMIT TO MENTAL HEALTH SERVICES: 5/30/06 — DATE OF Tx PLAN: 5/30/06

Presenting Symptoms *(partial list of symptoms frequently presented, check all that apply).*

- ___ Antisocial Behavior
- ___ Apathy
- ___ Bizarre Behavior
- ___ Blunted Affect
- ✓ Decrease in Energy or Fatigue
- ✓ Decreased Appetite
- ___ Delusions
  - ___ Grandeur
  - ___ Paranoid
  - ___ Persecutory
  - ___ Somatic
- ___ Distractibility
- ___ Dizziness or Lightheadedness
- ___ Excessive Worrying
- ___ Feelings of Hopelessness
- ___ Feigning of Symptoms
- ___ Flat Affect
- ___ Flight of Ideas
- ___ Hallucinations (Auditory)
- ___ Hallucinations (Visual)
- ___ Impaired Judgement
- ___ Incoherence
- ___ Insomnia
- ___ Loosening of Association
- ___ Loss of Interest
- ___ Memory Impairment
- ___ Mood Changes
  - ___ Anxious
  - ✓ Depressed
  - ___ Elevated
  - ___ Irritable
- ___ Neglect of Medical Condition
- ___ Persistent Anger
- ___ Pressured Speech
- ___ Psychomotor Agitation
- ___ Psychomotor Retardation
- ___ Racing Thoughts
- ___ Religious Preoccupation
- ___ Repeated Lying
- ___ Self-Mutilating Behavior
- ___ Sexual Preoccupations
- ___ Suicidal Ideation
- ___ Suicidal Gesture
- ___ Suicidal Attempt
- ___ Tremors
- ___ Untidy Appearance
- ___ Withdrawal/Detox from Drugs
- ___ Other (Specify)

Stressors *(check all that apply):*

- ___ Problems with other inmates
- ___ Problems with DOC
- ___ Recent death/losses
- ___ Spouse/child problems
- ___ Pregnant
- ___ Withdrawal/Detoxification from drugs
- ✓ Severe medical problems
- ___ Bing Issues
- ✓ Legal Issues *(specify)* incarceration/charges
- ___ Other *(specify)*

Patient Characteristics *(check whether the following characteristics are strengths or weaknesses of the patient):*

CHARACTERISTICS	STRENGTH	WEAKNESS	CHARACTERISTICS	STRENGTH	WEAKNESS
Compliant with Treatment	✓		Work History	✓	
Motivated for Treatment	✓		Interpersonal Skills	✓	
Support System	✓		Insight	✓	
Domiciled	✓		Health		✓
Education	✓		Hospitalizations	✓	

Diagnosis: Axis I [redacted]

Axis II [redacted] Axis III Reflex Sympathetic dystrophy Chronic Pain

Assessment of Problems and Needs *(see explanation of goals and objectives on opposite page).*

PROBLEM #1	GOAL	OBJECTIVE #1 Patient will...	OBJECTIVE #2 Patient will...
[redacted]	[redacted]	[redacted]	[redacted]
		TARGET DATE: 6/27/06	TARGET DATE: 6/27/06

NYC 0000054

PROBLEM #2	GOAL	OBJECTIVE #1 Patient will...	OBJECTIVE #2 Patient will...
		TARGET DATE:	TARGET DATE:

PROBLEM #3	GOAL	OBJECTIVE #1 Patient will...	OBJECTIVE #2 Patient will...
		TARGET DATE:	TARGET DATE:

Anticipated Date of Discharge from Treatment: _____

Treatment Modality and Frequency of Service: *(check all that apply and indicate frequency of service)*

	MODALITY	FREQUENCY OF SERVICE	RESPONSIBLE STAFF
✓	Clinician Visits	__ Weekly ✓ BiWeekly __ Monthly Other _____	MHC
	Psychiatrist Visits	__ Weekly __ BiWeekly __ Monthly Other _____	
	Group Therapy	__ Weekly __ BiWeekly __ Monthly Other _____	
	Art Therapy	__ Weekly __ BiWeekly __ Monthly Other _____	
	Substance Abuse Counseling	__ Weekly __ BiWeekly __ Monthly Other _____	

Level of Care: __ GP ___ MO ____ MHC _____ Bing ____ ✓ Infirmary

Name of Medications: __ __ NME _____ _____ _____

Patient's Statement of Involvement:

I have participated in the review of my treatment plan. I have discussed it with my Clinician/Psychiatrist and agree to participation in the plan

__ __ I want to add something:

_____

✓ Jayson Reyes	✓ Jayson Reyes	5/30/06
REVIEWED AND APPROVED BY — PRINT NAME	SIGNATURE	DATE
C. Lenfi, MHC	C. Lenfi, MHC	5/30/06
REVIEWED AND APPROVED BY — PRINT NAME	SIGNATURE	DATE
N/A	N/A	
REVIEWED AND APPROVED BY — PRINT NAME	SIGNATURE	DATE
David Jusick, PhD	David Jusick	5/31/06
REVIEWED AND APPROVED BY — PRINT NAME & TITLE	SIGNATURE	DATE

CORRECTIONAL HEALTH SERVICES
MENTAL HEALTH SERVICES

DISCHARGE SERVICE NEEDS

PATIENT'S NAME: FIRST Jason LAST: Reyes B&C #: 304-06-02628

Declined Discharge Planning Services:

☐ Yes, Date: NO

Borough of Residence Following Discharge:

☐ Manhattan ☑ Brooklyn/Staten Island
☐ Bronx ☐ Queens

Armed Forces:

☑ No ☐ Yes If, Yes: ☐ Honorable D/C or ☐ Other than Honorable

Current DSM-IV Diagnosis:

AXIS I: [redacted]
AXIS II: [redacted]
XIS III: [redacted]

Psychotropic Medication:

[redacted]

SPMI: ☑ NO ☐ YES

Community Treatment:

[redacted]

As Per The Patient:

☐ Monthly Income: $840.00 monthly or
☐ Plan of Support: _____

Community Services Currently in Place:

[redacted]

Entitlements:

[redacted]

Case Management:

[redacted]

Homeless Upon Discharge:

[redacted]

MICA:

[redacted]

State Sentenced:

[redacted]

Specific Referral(s):

_____

_____

X Jayson Reyes — X 5/30/06
REVIEWED AND APPROVED BY PATIENT NAME — DATE

C. Jenjè MH C — 5/30/06
REVIEWED AND APPROVED BY CLINICIAN NAME — DATE

Sonia Gonzalez — 5/31/06
REVIEWED AND APPROVED BY LICENSED CLINICIAN OR PROGRAM DIRECTOR NAME — DATE

CHS 200 Rev. 10/02

Utilization Management: Initial Review

1. **Treatment Plan Appropriateness:**

   A. Are the symptoms/problems clearly identified? ☑ Yes ☐ No

   B. Do the goals correspond with the symptoms/diagnoses? ☑ Yes ☐ No

   C. Are the goals achievable? ☑ Yes ☐ No

   D. Do the objectives correspond with the goals? ☑ Yes ☐ No

   E. Are the objectives observable/measurable? ☑ Yes ☐ No

2. **Treatment Recommendations:**

   A. Is the patient being treated at the appropriate level? ☑ Yes ☐ No

   B. Is the patient motivated/responsive to treatment? ☑ Yes ☐ No

3. **Discharge Service Needs Plan Recommendations** *(check all that apply):*

   ✓ Discharge service needs plan is appropriate to the treatment plan

   ✓ Discharge service needs plan approved

   ___ Modify treatment or discharge service needs plan: *(specify)* _____

   _____

   _____

   ✓ Planned date of discharge from treatment ___ pending courts

   ✓ Refer to next Utilization Management Review after approved number of sessions.

   ✓ Date of next review 6/27/06

Additional Comments:

Utilization Management Reviewer(s):

REVIEWED AND APPROVED BY LICENSED CLINICAL SUPERVISOR NAME | SIGNATURE | DATE

David Jurich, PhD | [signature] | 5/31/06

REVIEWED AND APPROVED BY 2ND REVIEWER NAME | SIGNATURE | DATE

CHS 286 (Rev. 10/03)

NYC Department of Health & Mental Hygiene
MENTAL HEALTH INTAKE FORM

Patient's Name: Reye Jason	
Book & Case Number: 2490602628	NYS ID Number: 04703424Y

DATE	BUILDING & HOUSING AREA	DATE OF BIRTH	AGE	ETHNICITY
5/6/06	NIC - D3	/13/85	21	Latino

ADDRESS	PRIMARY LANGUAGE	ABILITY TO SPEAK ENGLISH	Interpreter Needed?
[redacted]	[redacted]	[redacted]	[redacted]

EMERGENCY CONTACT PERSON	EMERGENCY TELEPHONE NUMBER	PATIENT REFERRED BY
[redacted]	[redacted]	Med

PRESENTING PROBLEM
(Include source of referral and patient's complaint)

Ref. by medical for MH ... for ... to assist with follow through of necessary medical interventions only, stressed bec. ... has not yet ... the ...

HISTORY OF PHYSICAL AND/OR SEXUAL ABUSE

A) Evidence of physical abuse *to* patient? ☐ YES ☒ NO

B) Evidence of sexual abuse *to* patient? ☐ YES ☐ NO

C) Evidence of physical abuse *by* patient? ☐ YES ☐ NO

D) Evidence of sexual abuse *by* patient? ☐ YES ☐ NO

SCREENING

Question	NO / YES	Comments
1. Are you experiencing depression, anxiety, or hallucinations?	[redacted] YES	[redacted]
2. Have you experienced any of these symptoms in the past?	[redacted] YES	
3. Have you had any previous mental health treatment?	[redacted] YES	[redacted]
4. Has anyone in your family ever been hospitalized for mental illness?	[redacted] YES	
5. Has anyone in your family taken medication for emotional problems?	[redacted] YES	
Do you or have you ever used alcohol or drugs? *(If yes, quantity, duration and type of drugs)*	[redacted] YES	[redacted]
7. Have you ever tried to hurt yourself? *(If yes, give reason, method, precipitant, and whether hospitalized)*	[redacted] YES	
8. Are you thinking about hurting yourself? *If yes, Why, and Do you have a plan?)*	[redacted] YES	
9. Do you see any other alternatives or solutions to the problems?	[redacted] YES	
10. Is there any history of family members trying to hurt themselves?	[redacted] YES	
11. Have you ever hurt anyone when you were angry or upset?	[redacted] YES	
12. Are you planning to hurt someone? *(If yes, Who?)*	[redacted] YES	

13. What you you do when you get upset? *(Describe coping mechanisms)* [redacted]

14. What are some recent stressors? *(Include reason for incarceration, punitive segregation time, or family/community issues)* This ... / ... expressed ... not to ... on ... where ... they were ... to ... the ...

15. Describe significant medical history: ...

CHS 290 (Rev 6, 04) NYC 0000058

This page redacted

THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Michael R. Bloomberg, *Mayor*

Thomas R. Frieden, M.D., M.P.H., *Commissioner*

nyc.gov/health

DISCHARGE SUMMARY – AFTERCARE LETTER

LAST NAME: Reyes FIRST NAME: Jason B/C#: 349-06-02628 FACILITY: NIC - Dorm - 3	NYSID#: 04704424Y DATE OF INCARCERATION 02/11/06 RELEASE DATE: 06-09-06

[4] Pt had declined DCP Services

DIAGNOSIS(s) Redacted

MEDICATION

[ ] Prescriptions

[4] Pt not receiving medication while incarcerated

[4] Medication – Medical ONLY

[ ] Medication refused

[ ] No meds dispensed at release: _____ (state reason)

[ ] Names of medication and dosages: _____

MEANS OF RELEASE

[4] Planned release

[ ] State prison/state jail

[ ] Release from Court: _____ (state type)

[ ] Unplanned release from RI _____ (state type)

SERVICES SECURED PRIOR TO RELEASE

[4] Community Services Brochure provided

[ ] Medicaid Application

[ ] DHS Referral

[ ] State Facility Referral

[ ] Borough LINK – Date of acceptance: _____

[ ] Brooklyn EAC LINK

[ ] Queens VOA

[ ] NYC FEGS

[ ] Bronx Fordham Tremont

[ ] Other:

[ ] Medication Grant Program Care provided

[ ] Public Assistance Application kit & referral

[ ] NYC HRA 2000 Application

[ ] Referred for Civil Hospitalization

[ ] Transportation

[4] Other: The Client will Return to 1866 60th Street Apt-3, New York, N.Y. Girl Friend - Roe Lopickelw - (646) 696-0554

[4] Community Treatment Provider(s): (specify name of providers, whether appointment was made or just referral, time, date and location of appointment and any other relevant information.)

The Client F/low-up W/ Private Physical Therapy at ONE-ON-ONE.

Patient: Jason Reyes Date: 6-09-06

Discharge Planner/Nurse/Clinician: Mary Fuentes Date: 6/9/06

THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Michael R. Bloomberg
Mayor

Thomas R. Frieden, M.D., M.P.H.
Commissioner

nyc.gov/health

AKA Jayson

DECLINATION OF DISCHARGE PLANNING

NAME: Jason Reyes

NYSID #: 04704424

B/C #: 349.06.02628

FACILITY: NIC-Annex Dorm 3

DATE: 06.06.06

This form serves to demonstrate that while I have been offered discharge planning services, I choose not to participate at this time. I am aware that I may seek assistance for discharge planning at any future point by notifying a member of the Mental Health Department.

I choose not to participate in the following:

[✓] All Discharge Planning Services
[ ] HRA Prescreening
[ ] Medicaid Application
[ ] Public Assistance Program, if SPMI
[ ] HRA 2000, if SPMI
[ ] Transportation, if SPMI or likely SPMI
[ ] Boro LINK Placement, if SPMI
[ ] Department of Homeless Services referral
[ ] Veterans referral
[ ] Medication upon release
[ ] Medication Grant Program Participation
[ ] Community Mental Health Placement
[ ] SPAN Brochure
[ ] Discharge Planning Rights Brochure
[ ] Disclosure of Medical Records to BRAD H Monitors

PATIENT'S SIGNATURE: Jason Reyes SSD 9840.W

DATE: 06-06-06

STAFF'S PRINTED NAME: Monique Andersen

STAFF'S SIGNATURE: Monique Andersen

DATE: 06-06-06

The above named patient has indicated his/her choice to decline all or some discharge planning services, and he/she has elected not to sign this document.

Staff's signature: _____ Date: _____

Witness: _____ Date: _____

PHYSICAL THERAPY PROGRESS NOTE

Name: Reyes, Jason Ars [redacted]: 349 06 02628 D/C 6/9/06 TS

DOB: 11/12/83 Clinic Name: PT Physician: RSD D3

MD Diagnosis: (L) foot 718 331-8751

Contraindications / MEDS:

Exercises	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
	5/9	5/24	5/31	6/7	6/12					
ice	✓									
TENS (LBP)		✓	✓	✓	D/C					
MHP		✓	✓	✓	pt transferred					
massage		✓	✓	✓						
					home HEP					
					Instructed					
					to possibly upload					
Therapist Initials										

Physical Therapist Signature: [signature] P.T.

5/24/05 - Pt has been [illegible] clinic [illegible] w/ poor results; pt has s/s of RSD to the Ⓛ medial/lateral/plantar s. of foot c hyper pain reaction to lite touch even on affected areas; currently tx for LBP pain relief c trunk massage (posterior); pain, relief attempt, will try tx recommended in P.T. magazine for RSD that recommends TENs to the associated spinal nerve. contralateral electrode placement [illegible]

5/31/06 - Recent studies indicate use of Tens c acupuncture pts. being employed. parameters to be high/low c contralateral spinal e placement and LE trigger points employed (+ knee, between fib/tib), [illegible] Pt recvd 30 min.; review pt reaction @ next appt. cont P.T. [illegible]

6/8/06 - Pt possible D/c; provided clinically evidence for RSD tx. Cont PT if held. [illegible]

CONSULTATION REQUEST

Leave blank for hospital use

[illegible]

'EW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Patients' Name [illegible], JASON DOB [illegible]

FROM [illegible] Correctional institution [illegible] Inmate no.

Referred to [illegible] Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

[illegible]

Diagnosis, treatment and medications by C.H.S.:

RSD [illegible]

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

[illegible]

Request: [illegible]

Date 5/4/06 Referring Physician [illegible] Phone ________ Approved [illegible]

Consultation, findings and recommendations:

Pt has [illegible] of RSD, 2° to work rel. injury [illegible]

[illegible]

Date ________ [illegible]ician ________

NYC 0000064

Reminder: Fully Complete the Problem List

CHS F014 Rev 5/04

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name _____ DOB _____

FROM _____
Correctional institution Inmate no.

Referred to _____ Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date _____ Referring Physician _____ Phone _____ Approved _____

Consultation, findings and recommendations:

Date _____ Physician _____

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
ND MENTAL HYGIENE

Leave blank for hospital use

PT

Patients' Name REYES, JASON DOB 1/13/83

FROM NIC 03 / 349060262B
Correctional institution Inmate no.

Referred to PT Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

23 YO M HX OF

Diagnosis, treatment and medications by C.H.S.:

RSD REFLEX SYMPATHETIC DYSTROPH
SINCE SCST 2002

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

BILATERAL LEG PAIN + WEAKNESS

HYPERESTHESIA TO (L) HEEL

Request: PT FOR ROM TO
LOWER EXTREMITIES (AS TOLERATED)

Date 5/4/06 Referring Physician ~~Thomas Schwaner, PA~~ Phone Harvinder Bhatti, MD Approved

Consultation, findings and recommendations:

NYC 0000066

Pt has report of RSD, 2° to work related injury. S/S of RSD to (L) foot m/l and plantar surface c ↓ ROM @ ankle c/p evident. pt has hyperkeratosis in (L) CA c cognitive oscillations evident when transferring w. Bx or walking. gait is impaired by RSD c ↑ (6/10) pain levels brought on with w.B. ↓ to ↓ pain c physical agents (U.S. Russ) return to P.T. Dyskinesia

Date Physician

CHS 5014 (Rev 10/94) Reminder: Fully Complete the Problem List

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

8/1
(2 weeks)

Patients' Name Reyes Jason DOB 1/13/83

FROM N.C. D.A. / 3490612628
Correctional institution Inmate no.

Referred to Neurology Ward / Clinic

Hospital BVH / Clinic no.

Chief complaint or findings: 23 y/o → with H/o Reflex sympathetic dystrophy discharge from BVH 4/18/06 recommended F/u Neuro in 2 w/s.

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Meds Neurontin 300 → TID
Cymbalta 40 → daily
Lidoderm patch q12h prn
Oxycontin SR 10 → PO q12h
Allergy Fentanyl

Request:

(HABIB KAMKHAJI, M.D.)

Date 4/18/06 Referring Physician _____ Phone 1252 Approved Rajeev L. Ashrafi, MD

Consultation, findings and recommendations:

Date _____ Physician _____

HS 5014 (Rev. 5/04) *Reminder: Fully Complete the Problem List* NYC 0000067

CORRECTION DEPARTMENT
CITY OF NEW YORK

COMMAND: NIC

DATE: 6/1/06

SPECIALTY CLINIC REFUSAL FORM

PART A

INMATE'S NAME: Reyes, Jason

BOOK AND CASE NUMBER: 3490602628

CLINIC:

CLINIC LOCATION: Bellevue

APPOINTMENT DATE: 6/1/06

I REFUSE TO GO TO MY SCHEDULED MEDICAL TREATMENT ON THIS DAY:

(SIGNATURE OF INMATE)

WITNESSED BY (CLINIC STAFF): Habib Kamkhaji, MD
(PRINT NAME)

(SIGNATURE OF STAFF MEMBER) 6/1/06 (DATE)

REASON FOR REFUSAL

CORRECTION DEPARTMENT
CITY OF NEW YORK

CLINIC SITE:

DATE: / /

SPECIALTY CLINIC REFUSAL FORM

PART B

INMATE'S NAME:

BOOK AND CASE NUMBER:

CLINIC:

APPOINTMENT DATE: / /

I REFUSE TO HAVE MY SCHEDULED MEDICAL TREATMENT ON THIS DAY.

(SIGNATURE OF INMATE)

REASON FOR REFUSAL

INTERVIEW CONDUCTED BY (PRINT NAME) | RANK | SHIELD # | SIGNATURE

CORRECTION DEPARTMENT
CITY OF NEW YORK

COMMAND: NICDA

DATE: 6/1/06

SPECIALTY CLINIC REFUSAL FORM

PART A

INMATE'S NAME: Reyes, Jason

BOOK AND CASE NUMBER: 3490602628

CLINIC:

CLINIC LOCATION: Bellevue

APPOINTMENT DATE: 6/1/06

I REFUSE TO GO TO MY SCHEDULED MEDICAL TREATMENT ON THIS DAY:

(SIGNATURE OF INMATE)

WITNESSED BY (CLINIC STAFF):

Habib Kamkhaji, MD
(PRINT NAME)

(SIGNATURE OF STAFF MEMBER)

6/1/06
(DATE)

REASON FOR REFUSAL

CORRECTION DEPARTMENT
CITY OF NEW YORK

CLINIC SITE:

DATE: / /

SPECIALTY CLINIC REFUSAL FORM

PART B

INMATE'S NAME:

BOOK AND CASE NUMBER:

CLINIC:

APPOINTMENT DATE: / /

I REFUSE TO HAVE MY SCHEDULED MEDICAL TREATMENT ON THIS DAY.

(SIGNATURE OF INMATE)

REASON FOR REFUSAL

INTERVIEW CONDUCTED BY (PRINT NAME) | RANK | SHIELD # | SIGNATURE

NYC HEALTH AND HOSPITAL CORPORATION

CORRECTIONAL HEALTH SERVICES

AFTER CARE LETTER

BC# 349060262[illegible]

AFTER CARE LETTER

Date: 6/8/06

To Whom It May Concern:

Patient REYES, JAYSON has been under our care for the following conditions:

I. Health Problems

II. Treatments, Medications, Date, Follow-Up Needs

Reflex Sympathetic dystrophy → Neurology f/u at B[illegible]

[illegible]

Follow-up care is required for the above conditions(s)

Clinic Tel. # (718) 546-[illegible]

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

Patients' Name REYES, JASON DOB 1/3/53

FROM NIC / 3490602628
Correctional institution MEDICAL Inmate no.

Referred to [redacted] Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

Diagnosis, treatment and medications by C.H.S.: PATIENT STATES WHEEL CHAIR THAT WAS GIVEN TO HIM FROM BELLEVUE HOSP WAS PLACED IN STORAGE ON 5/25/06

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request: PLEASE RETURN IT TO PATIENT IF POSSIBLE

THANK

THANK

Date 5/30/06 Referring Physician Thomas Schwaner, PA Phone Approved

Consultation, findings and recommendations:

NYC 0000071

Date Physician

CHS 5014 (Rev. 5/04) *Reminder: Fully Complete the Problem List*

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE CHS FORM

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	INDICATION						
3	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	INDICATION						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	INDICATION						
2	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	INDICATION						
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	INDICATION						

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	34906026 2 8	NIC 13	NKA

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	COMBIVENT	60 mg	PO	QD	7d		
	INDICATION	CHRONIC PAIN MGN					
1	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	PROVIGIL	200 mg	PO	QAM	7d		
	INDICATION	CHRONIC PAIN MGN					
	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
	OXYCONTIN SR	20 mg	PO	BID	7d		
	INDICATION						

Roslynn Glicksman, MD

DATE	TIME	PRESCRIBER SIGNATURE	STAMP		RPh
6/6/06			0284		

Write medication orders beginning from bottom of page
Chart Copy–White; Pharmacy Copy–Yellow

NYC 0000072

NEW YORK CITY DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CHS FORM B

MEDICATION ORDER SHEET

USE BALL POINT PEN AND PRESS FIRMLY

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349060262	28 NIC D3	NKA

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
3	COMPACTA	60 mg	PO	QD	7d		
	INDICATION: CHRONIC PAIN MGT						
	PROVIGIL	200 mg	PO	QAM	7d		
	INDICATION						
	OXYCONTIN	20 mg	PO	BID	7d		
	INDICATION						

DATE 6/2/06 | TIME | PRESCRIBER SIGNATURE | STAMP: Roslynn Glicksman, MD 0864 Thomas Schwaner, PA | RPh

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349060262	28 NIC D3	

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE TIME
2	COMPACTA	60 mg	PO	QD	7d		
	INDICATION						
	PROVIGIL	200 mg	PO	QAM	7d		
	INDICATION						
	DRUG	DOSE	ROUTE	FREQUENCY: Marie [illegible] 07/5	DURATION	NURSE	DATE TIME
	INDICATION						

DATE 5/30/06 | TIME | PRESCRIBER SIGNATURE | STAMP: 0864 Thomas Schwaner PA | RPh [illegible] MD

PATIENT LAST NAME	FIRST NAME	BOOK & CASE NUMBER	HOUSING AREA	ALLERGIES
REYES	JASON	349060262	NIC D3	

	DRUG	DOSE	ROUTE	FREQUENCY	DURATION	NURSE	DATE/TIME
1	LIDOCAINE PATCH	T	TOPICAL	QD	30d		
	INDICATION						
	(↑) NEURONTIN	1000 mg	PO	TID	30d		
	INDICATION						
	OXYCONTIN SR	20 mg	PO	BID	7d		
	INDICATION						

DATE 5/30/06 | TIME | PRESCRIBER SIGNATURE | STAMP: 0864 Thomas Schwaner, PA | RPh: Marie [illegible] 07/5 [illegible] MD

Write medication orders beginning from bottom of page.
Chart Copy–White; Pharmacy Copy–Yellow

CHS [illegible] (4/94)

NYC 0000073

CONSULTATION REQUEST

NEW YORK CITY DEPARTMENT OF HEALTH
AND MENTAL HYGIENE

Leave blank for hospital use

D3
Elmhurst
on 5/26

Patients' Name REYES, JASON DOB 1/13/83

FROM NIC 03 / 349 0602628
Correctional institution Inmate no.

Referred to MENTAL HEALTH Ward / Clinic

Hospital / Clinic no.

Chief complaint or findings:

23 YO M PMHx of
REFLEX SYMPATHETIC DYSTROPHY
CHRONIC PAIN + DIFFICULTY
IN PREVIOUS HEALTH PATIENT
FEELS SAD AT TIMES
RISK FOR DEPRESSION

Diagnosis, treatment and medications by C.H.S.:

Other pertinent physical, psychiatric, and historical findings, including lab values and x-ray findings:

Request:

Date 5/25/06 Referring Physician T K PA Thomas Schwaner, PA Phone Roslynn Glickspiegel, MD Approved 5/26/06

Consultation, findings and recommendations:

Pt. out to EHPW on 5/26/06
Pt. at EHPW 5/27/06. k.j.

5/30/06 Pt seen today by mental Health
7:30pm full psychosocial hx of Comprehensive
Tx plan discussed
will Fup.

C. Anje, ARNP

Date _____ Physician _____

New York City Department of Health and Mental Hygiene

PATIENT REFUSAL OF TREATMENT

Patient Addressograph

B.H. NEURO PSY
SURGERY 1st

Reyes Jason 34906028 628 **CHS FORM C**

This is to certify that I am over the age of 18 years and I am refusing the following:

- ☐ Medical Evaluation [History and Physical]
- ☐ Medical Services
- ☐ Administration of Medication (other than psychiatric)
- ☐ Laboratory Services
- ☐ Diagnostic Testing
- ☐ Other _____
- ☐ Mental Health Evaluation
- ☐ Mental Health Services
- ☐ Administration of Psychiatric Medication
- ☐ X-ray Services
- ☑ Clinic Appointment at BUH

I understand this refusal is against the advice of my health care providers. I acknowledge that I have been informed of the risks, consequences and the danger to my health and possibly to my life which may result from my refusal of this procedure/treatment.

I have been given time to ask questions about my condition and about my decision to refuse the procedure/treatment which my health care provider has explained to me is medically indicated and necessary.

I voluntarily assume the risks and accept the consequences of my refusal of the procedure/treatment and I am releasing all of the health care providers, the facility and its staff from any and all liability for ill effects that may result from my refusal of treatment.

Pt was not able to sign because of hand checking, DOC form signed

_____ 6/1/06
Signature of Patient **Date**

Two Witnesses: I, Clothen Collins a health care staff member who is not the patient's health care provider for this procedure and I have witnessed the patient voluntarily sign this form.

Clothen Collins
Signature and Title of Witness

I, _____ am not the patient's health care provider for this procedure and I have witnessed the patient voluntarily sign this form.

_____
Signature and Title of Witness

Interpreter, Translator: [To be signed by the interpreter/translator if the patient require such assistance] To the best of my knowledge the patient understood what was interpreted, translated and voluntarily signed this form.

_____
Signature of Interpreter Translator

CHS FORM C

REFUSAL OF TREATMENT PROGRESS NOTE
(The Refusal of Treatment Form C on the reverse side must also be completed)

Patient Addressograph

On 6/1/06 (Date), the above-named patient refused the treatment/ procedure which is medically or psychiatrically indicated and necessary. I explained the risks, consequences and danger to the health and possibly the life of the above-named patient.

As I explained to the patient, the risks, consequences and dangers of refusing the treatment/ procedure include but are not limited to:

pt refuses clinic Appt & BMP TCA
Risks + Benefits + Alternatives explained, pt states
he can not go Today but he agrees to be rescheduled
F/u PA/MD TCA

I provided the above-named patient with the opportunity to ask questions. I have answered the questions asked and it is my professional opinion that the patient understands what I have explained.

Signature of Attending Physician or Authorized Health Care Provider[1]

6/1/06
Date

Habib Kamkhaji, MD
Print Name and Identification Number

[1]Authorized Health Care Provider is one who is credentialed and privileged by the medical staff to perform this diagnostic test, procedure or surgery that requires informed consent. See also HHC Consent Policy, Article III

CHS 505 (Rev. 3/04)

Elmhurst Hospital Center
Discharge/Transfer Summary
79-01 Broadway Elmhurst, New York 11373

Discharge/Transfer Summary

Patient:	Reyes,Jason	DOS:	05/27/06
MR - V#:	2703710-1	Report Date:	05/27/06
DOB/Age/Sex:	01/03/83 23Y M		
Order Author:			
Location:	B4-11 01		

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Unscheduled Discharge/Transfer Summary
Event Time: Sat, 27 May 06 0851 Status: complete

Sat, 27 May 06 1014 Documented by Ching Hung Chang, MD

Admit Date : Thu, 25 May 2006
Disposition : Discharge
Discharge Date : Sat, 27 May 2006
Discharge Location : Rikers
Patient Condition : stable
Adm BP : 130/103 mm Hg
Adm Pulse : 117 bpm
Adm Resp : 21
: 189 lbs 0 oz (85729 g, 86 kg)
: 5'8" (68 in, 173 cm)
CC/HPI : Chest Pain 23 yo M with chest pain radiating to his back .
Adm Appearance : Abnormal tremulous, appears uncomfortable
Adm HEENT : Normal
Adm Cardiac : Normal PMI, S1 S2 no murmurs, gallops or rubs
Adm Periph Vasc : Dorsalis pedis pulse +2
Adm Pulmonary : Clear to auscultation
Adm Abdomen : +BS, no rebound or guarding
Adm Skin : No rashes, lesions or ulcers
Adm MSK/Extremities: pain in left lower extremity to palpation
Adm Neurological : Normal
BP : 116/70 mm Hg
Pulse : 79 bpm
Resp : 16
Temp : 97 F (36 C)
Appearance : Normal
Cardiac : Normal PMI, S1 S2 no murmurs, gallops or rubs
Pulmonary : Clear to auscultation
Abdomen : +BS, no rebound or guarding
MSK/Extremities: pain when pressing of chest lateral to sternum